This resource contains excerpts from *Women & Tobacco: A Casebook*. The complete casebook can be downloaded from www.coalescing-vc.org/tobacco.
Girls, Women, and Tobacco: Global Trends

**IN SUM**
While global tobacco-use trends among men are now declining, overall tobacco use among girls and women are continuing to rise in the 21st century.

**SOURCE**

**RESOURCES**


Nearly 20 percent of the world’s population smokes cigarettes, including about 800 million men and 200 million women. Global rates of male smoking have peaked, while rates of women’s smoking are on the rise. The World Health Organization predicts that the prevalence of smoking among women worldwide will be 20 percent by 2025 - a sharp contrast to the 12 percent of the world’s women who smoke today.

In countries where women have been smoking for some time, tobacco related deaths are high. In other countries the historical gender gap between girls’ and boys’ tobacco use is narrowing. Successfully addressing tobacco-use trends requires interrupting the rise in women’s tobacco use as well as women’s exposure to secondhand smoke.

We present a few statistics below from the *Tobacco Atlas* produced by the American Cancer Society and the World Lung Foundation which provides a glimpse at patterns of tobacco use among girls and women around the world today.

- More than half of all countries have a female smoking prevalence rate of less than 10%.
- There are at least 49 countries in which ten times more men than women smoke.
- In contrast, in most of the world, the difference in smoking rates between girls and boys is small. In fact, more girls smoke than boys in at least 25 countries.
- Sweden and Nauru are the only two countries in the world where smoking prevalence is higher among women than men.
- In some countries, like Finland and Egypt, men use smokeless tobacco products (such as snuff, snus, or gutka) in much greater numbers than women because such products are perceived as masculine.
- In countries like South Africa, Thailand, and Bangladesh, women use smokeless tobacco products more than men because they are seen as a discreet way to consume tobacco.

**PLACES WHERE SUBSTANTIALLY MORE GIRLS THAN BOYS SMOKE CIGARETTES** *(ages 13-15, 2010)*

<table>
<thead>
<tr>
<th>Country</th>
<th>% Boys</th>
<th>% Girls</th>
<th>% More Girls</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chile (Santiago)</td>
<td>28.0</td>
<td>39.9</td>
<td>11.9%</td>
</tr>
<tr>
<td>Argentina</td>
<td>21.1</td>
<td>27.3</td>
<td>6.2%</td>
</tr>
<tr>
<td>Uruguay</td>
<td>16.4</td>
<td>22.9</td>
<td>6.5%</td>
</tr>
<tr>
<td>Cuba</td>
<td>8.7</td>
<td>13.1</td>
<td>4.4%</td>
</tr>
<tr>
<td>Brazil (Sao Paulo)</td>
<td>9.2</td>
<td>13.2</td>
<td>4%</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>24.4</td>
<td>31.6</td>
<td>7.2%</td>
</tr>
<tr>
<td>Slovenia</td>
<td>15.2</td>
<td>23.0</td>
<td>7.8%</td>
</tr>
<tr>
<td>Sweden</td>
<td>5.0</td>
<td>13.0</td>
<td>8%</td>
</tr>
<tr>
<td>New Zealand</td>
<td>14.5</td>
<td>20.6</td>
<td>6.1%</td>
</tr>
</tbody>
</table>

**THE NEXT STEP**
1. Globally, tobacco use is increasing for girls and young women, and in some cases surpassing rates for boys. How does this fit with your experience?
2. What policies and services are in place in your community/region/country that directly address girls’ and women’s tobacco use?
Women Working in the Health Care System and Tobacco Control

IN SUM

Women health care providers can play multiple roles in tobacco control. For example, introducing gender analysis into the design and delivery of programmes; supporting the development of women-specific smoking cessation programs within their professional organizations; advocating for smoke-free hospitals; and improving health curricula to include information on gender, women and tobacco use and cessation.

Research has shown that brief counselling by health care providers on the harms of smoking and the importance of quitting is one of the most cost-effective methods of reducing tobacco use. Given the health consequences of tobacco use, few would argue that health care workers, including physicians, nurses, midwives, dentists, psychologists and pharmacists, have an important role to play in the tobacco control movement. Historically, many health care providers have had an ambivalent relationship with tobacco use. Images of physicians and nurses have been used in advertising to support the supposed safety of cigarettes, to glamorize women working in health care, and to encourage tobacco use in health care workers. In some countries, rates of smoking in certain groups of health care providers remain higher than rates in the general population. In many countries, rates of smoking have stabilized or declined in men but are still increasing for women, a trend reflected in smoking rates in health care workers.

In the past thirty years, individual health care providers and health professional organizations have become involved in addressing tobacco use in a range of ways. As many health care professions are predominately made up of women, women are often taking a leadership role in supporting cessation efforts, developing programming, and advocacy (e.g., efforts to make hospitals smoke-free). As just one example, in 1999, the 600,000 member Japanese Nursing Association, Japan's largest women's professional organization, campaigned to stop smoking among nurses and to make hospitals smoke-free. The rate of smoking among nurses (25.7%) was twice that of all Japanese women in 2001. JNA published booklets on quitting smoking and organized many seminars to train leaders for cessation programmes. In 2006, the nurses' smoking rate had dropped by 6% to 19%.

NURSE IN A SMOKING ADVERTISEMENT, 1932. Source: http://tobacco.stanford.edu/tobacco

Sources


Percent of countries with smoke-free health facilities (2010 or latest available, World Tobacco Atlas, 2012)

<table>
<thead>
<tr>
<th>Region</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Americas</td>
<td>49%</td>
</tr>
<tr>
<td>Europe</td>
<td>64%</td>
</tr>
<tr>
<td>Eastern Mediterranean</td>
<td>59%</td>
</tr>
<tr>
<td>Western Pacific</td>
<td>44%</td>
</tr>
<tr>
<td>South-east Asia</td>
<td>100%</td>
</tr>
</tbody>
</table>
RESOURCES

The NET (special issue on nurses and tobacco control), E-zine of the International Network of Women against Tobacco September 2009-February 2010 issue 

The Nightingale Nurses www.nightingalesnurses.org
Includes sample letters to send to newspapers, tobacco companies, and magazines that include tobacco advertising. Information about the tobacco industry and resources for nurses to help smokers quit.

Outsmart Tobacco www.outsmarttobacco.org
The blog of nurse, Joan O’Connor, includes a range of resources that nurses can use with their clients. Since 2008, Joan has been keeping track of every cigarette not smoked by members of her ‘Tobacco Fighters and Survivors Club,’ a smoking reduction and cessation group for people living with mental illness.

Tobacco Free Nurses www.tobaccofreenurses.org

THE NIGHTINGALE NURSES

The Nightingale Nurses are a group of nurse activists who volunteer to educate nurses and the public about the tobacco industry. The Nightingales group was founded in 2004 after Ruth Malone, a nurse researcher at the University of California, San Francisco, uncovered hundreds of letters while conducting research using internal tobacco industry documents that were released in the 1990s. The letters had been sent by consumers and their grieving families from across the country to tobacco companies, asking them to stop sending coupons, catalogs, birthday cards, and other materials in the mail. The letters became one way to draw public attention to the actions of the tobacco industry and its contributions to tobacco-related disease and illness.

In 2011, the group had about 200 members. The group uses a range of strategies to challenge the tobacco industry. Since 2004, the Nightingales have attended annual shareholder meetings of tobacco companies after members have bought a company share in order to become a shareholder. At the meetings, they voice their concerns as health care providers who witness the negative effects of tobacco products and question claims of social responsibility. The first meeting attended was at Altria/Philip Morris, the largest multinational tobacco company in the world. At that meeting, one of the Nightingales asked the board members and directors for two minutes of silence to remember the people she cared for who had died due to tobacco use.

The Nightingales Nurses have also launched the RN2Q1 campaign. The campaign encourages every nurse to help at least one person to quit tobacco every year. Other activities include targeting tobacco advertising and marketing practices.

LIBERATION! A GUIDE TO WOMEN-CENTRED TOBACCO TREATMENT

Liberation! A Guide to Women-Centred Tobacco Treatment supports health care providers to implement brief tailored tobacco interventions for women. This resource was developed as a guide, rather than a manual, to help shift away from a prescriptive approach to smoking cessation and to emphasize the collaborative and dynamic nature of real-life clinical interactions. It is meant to support brief interventions, from 5 to 30 minutes, and can be used by practitioners in various contexts and roles.

THE NEXT STEP

1. What have you noticed about how tobacco issues for women in particular, are treated within the health care system?
2. Who are (or might be) leaders in promoting action on women and tobacco in your community/region/country?
Research has clearly shown that interventions by health care providers can increase quitting rates significantly among current smokers and recent quitters. Brief interventions are tools and approaches that health care providers can incorporate into their practice that take approximately 3 - 15 minutes. Brief interventions can be provided by all health care providers but are most relevant to clinicians who see a wide variety of patients and are bound by time constraints (e.g., physicians, nurses, physician assistants, nurse practitioners, medical assistants, dentists, hygienists, respiratory therapists, mental health counselors, pharmacists, etc.).

One of the earliest and most popular brief interventions is the “5 As” model developed by the U.S. Department of Health and Human Services. This model incorporates the latest clinical guidelines for treating tobacco use and dependence and has been used in a range of settings and populations, including women of childbearing age and pregnant and postpartum women. The five A’S are ASK, ADVISE, ASSESS, ASSIST, and ARRANGE.

**Ask** about tobacco use - Identify and document tobacco use status of every patient at every visit.

**Advise** to quit - In a clear, strong and personalized manner urge every tobacco user to quit.

**Assess** for current tobacco use - Is the tobacco user willing to make a quit attempt at this time? For the ex-tobacco user, how recent did you quit and are there any challenges to remaining abstinent?

**Assist** - For the patient willing to make a quit attempt, offer medication and provide or refer for counseling or additional behavioral treatment to help the patient quit. For patients not yet ready to quit, use motivational interventions designed to increase future quit attempts. For the recent quitter and any with remaining challenges, support relapse prevention.

**Arrange** - All those receiving the previous A’s should receive follow-up.

In recent years, brief interventions based on principles of motivational interviewing have become popular, especially as research to support this type of approach for a range of
health issues continues to grow. In the tobacco cessation field, motivational interviewing is particularly helpful for health care providers who are interested in approaches to supporting patients who are not ready to make a quit attempt or have recently relapsed.

Motivational interviewing is an evidence-based clinical approach for encouraging patients to discuss and consider their own personal motivations and resources for making positive changes in behaviour in the interest of their health. Health care providers use a range of techniques to explore feelings, beliefs, ideas, and values regarding tobacco use in an effort to explore with the smoker, ambivalence about using tobacco. Building on this ambivalence, health care providers encourage “change talk” (e.g., reasons, ideas, needs for eliminating tobacco use) and commitment (e.g., intentions to take action to change smoking behavior, such as not smoking in the home). Research has shown that having patients use their own words to commit to change is more effective than clinicians merely providing information or telling patients that they need to quit.

While many women succeed in quitting smoking with generic or mainstream interventions to quitting smoking, many do not. As the evidence and understanding of sex- and gender-related influences on smoking and cessation behaviours continues to grow, work is being done to identify principles and practices for cessation interventions tailored for women.

The following four principles have been identified by researchers at the British Columbia Centre of Excellence for Women’s Health:

1. **Women-centred care for tobacco is tailored** - A tobacco-dependence program that is tailored specifically for women supports a woman’s readiness to quit and allows her to have choice and control over the intervention components, including the use of pharmacotherapy.

2. **Women-centred care for tobacco builds confidence and increases motivation** - Working with women to identify gender specific barriers and opportunities for change helps build confidence and motivation, ultimately improving their chances of meeting smoking cessation goals.

3. **Women-centred care for tobacco integrates social justice issues** - Women-centred care acknowledges other priorities such as housing, food security, and caregiving roles and how these challenges may be related to smoking behaviour.

4. **Women-centred care for tobacco is holistic and comprehensive** - Women-centred care integrates support/treatment for trauma, mental health recovery, substance use, or other important health concerns which the woman identifies; valuing women’s health for its own sake.

Many women-centred approaches can be applied in primary care settings as well as in more specialized (e.g., mental health treatment) and group settings.

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**THE NEXT STEP**

1. If you are a health care provider who uses the 5 As model in your work, how can you adapt or expand the model to consider some of the unique issues that women may be facing as they address their tobacco use?

2. What do you think are the benefits of motivational interviewing for a women-centred approach to tobacco reduction and cessation?
Strategies for Reducing Tobacco Use with Pregnant and Postpartum Women

IN SUM

Close to half of pregnant women who smoke either seriously consider or take steps towards stopping during pregnancy. Unfortunately, high postpartum relapse rates suggest that pregnant and postpartum women have unique smoking cessation needs. Over the past thirty years, smoking in pregnancy has attracted increased attention in the tobacco-intervention field. Unfortunately, health interventions designed to reduce smoking during pregnancy have not been resoundingly successful. Evidence in more industrialized countries suggests that the drop in smoking over time among pregnant women has been primarily caused by an overall decline in smoking rates among women of childbearing age, not by increased rates of smoking cessation in pregnancy. One reason for this lack of success seems to be an emphasis on improving fetal health only, and reducing future health-care costs for premature and low-birth weight babies. Such interventions pay less attention to the pregnant women’s overall health and to women’s smoking before and after pregnancy.

Many women feel intense pressure to stop smoking when they become pregnant. This pressure comes from partners, family members, the media, etc. Pregnant women who are unable to reduce or stop smoking often feel guilty and ashamed about their smoking. While many women are able to quit smoking when they become pregnant, approximately 70 % of women resume after they give birth. For these women, reduction during pregnancy is often not truly voluntary; many have undergone what researchers refer to as “compelled tobacco reduction.”

Helping pregnant women to quit or reduce smoking is different from helping other smokers. Pregnant smokers have unique cessation issues (e.g., social pressures to quit, physiological changes, brief time period to

FIVE WAYS TO CHANGE YOUR PRACTICE: SUGGESTIONS FOR HEALTH CARE PROVIDERS WHO WORK WITH PREGNANT AND POSTPARTUM GIRLS AND WOMEN

In 2010, the British Columbia Centre of Excellence for Women’s Health in Vancouver, BC conducted a best practices review to examine smoking cessation interventions tested in pregnant populations. The review showed that, when it comes to prenatal care, many health care providers believe that they don’t have adequate time to address smoking, or that the stress of stopping smoking may negatively affect the fetus or the mother’s ability to care for her child after birth. While pregnancy can increase women’s stress level, there is no evidence to suggest that quitting smoking during pregnancy increases stress or negatively impacts the health or well being of the woman or the fetus. On the contrary, there is a wealth of evidence to suggest that stopping, reducing, or quitting smoking has great health benefits for woman, fetus and baby.

The Expecting to Quit website includes a section called “Five Ways to Change Your Practice” for health care providers which provides an overview of brief smoking cessation interventions for pregnant and postpartum girls and women.

SOURCES

Bottorff, J. L., Carey, J., Poole, N., Greaves, L., & Urquhart, C. (2008). Couples and smoking: What you need to know when you are pregnant. Vancouver, BC: Jointly published by the British Columbia Centre of Excellence for Women’s Health, the Institute for Healthy Living and Chronic Disease Prevention, University of British Columbia Okanagan, and NEXUS, University of British Columbia Vancouver. Available from: www.facet.ubc.ca


Families Controlling and Eliminating Tobacco (FACET) website
Research and resources for supporting tobacco reduction for pregnant and postpartum women and new fathers. Available from: www.facet.ubc.ca
make changes) compared to other women. High postpartum relapse rates demonstrate that we need to treat pregnant and postpartum women differently than other smokers. Pregnant women often appear to experience the “quitting” process, but end up returning to smoking behaviour.

During pregnancy, nicotine replacement therapies (NRTs) are not completely free of risk, but evidence suggests that NRTs are less harmful than smoking during pregnancy because both the woman and fetus receive less nicotine and no exposure to carbon monoxide and other toxic substances. For some groups of women, where other avenues to quit or reduce have not been successful, NRTs may be an option to discuss further.

Other strategies to support pregnant and postpartum women include:

- Ensuring that public health messages are framed in a sensitive, nonjudgmental way that is relevant to the social and economic circumstances of women’s daily lives;
- Encouraging harm reduction among pregnant smokers by recommending and supporting: a decrease in the number of cigarettes they smoke, brief periods of cessation at any point in pregnancy and around delivery, and health-promoting behaviours such as exercising and addressing partner smoking;
- Encouraging women to continue breastfeeding even if they smoke or are using NRTs to aid their cessation.

### THE NEXT STEP

1. Approaches to smoking cessation that focus on the health of the fetus, focus the motivation for quitting away from woman’s own health. Yet the well-being of the fetus can be a key motivator for some women. How does this relate to high rates of relapse following pregnancy? What other strategies can be used to support women?

2. How do you feel about harm reduction approaches to addressing smoking during pregnancy where women are encouraged to cut down on their smoking as opposed to quitting altogether?

### COUPLES, SMOKING, AND COMPELLED TOBACCO REDUCTION

There is evidence that partners and family members play a powerful role in influencing whether pregnant women quit smoking and are able to maintain abstinence in the postpartum period. Compared to pregnant women who live with non-smokers, those who live with a partner who smokes are less likely to stop smoking during pregnancy and more likely to relapse during the postpartum period. However, if a partner is resistant to quitting smoking, encouraging the woman to ask her partner to quit with her may cause tension in the relationship. In other cases, the woman is pressured by her partner to quit, making her process more difficult. Considering the possible stress that smoking cessation may put on a woman’s relationship (with the possibility for elevated frustration and anger), partner cessation should be considered and supported separately from the woman’s own attempt to quit.

**RESOURCES**

Expecting to Quit: Smoking Cessation Interventions for Pregnant and Postpartum Girls and Women

www.expectingtoquit.ca
Women-Centred Approaches to Smoking Cessation Drugs and Nicotine Replacement Therapies (NRTs)

Some governments are now introducing policies related to covering the cost of smoking cessation products and nicotine replacement therapies (NRTs). The British Columbia (BC) program, introduced in September 2011, covers two types of smoking cessation aids: (1) Prescription smoking cessation drugs such as bupropion (brand name Zyban®) and varenicline (brand name Champix®) or (2) Non-prescription nicotine replacement therapy NRT gum or patches such as Thrive™ nicotine chewing gum and Habitrol® nicotine patches.

The governmental funding provided many health care centres with the opportunity to review their approaches to smoking cessation support. At the Maxxine Wright Health Centre in Surrey, BC, the multidisciplinary team of health and social service professionals began a nicotine replacement therapy demonstration project in 2011. The Maxxine Wright Health Centre (MWCHC) is a primary health clinic serving pregnant and early parenting women impacted by violence and/or substance misuse. The multidisciplinary care team provides comprehensive healthcare to women and children including methadone and prenatal care services, as well as support staff for social services such as housing, networking and advocacy. Many MWCHC clients are multi-barriered, facing complex issues such as gender-based violence, mental health and/or addiction concerns, poverty, food insecurity,
insecure housing or homelessness, and many are marginalized from traditional healthcare services related to these barriers. Because little is known about what helps women who are facing these types of issues to quit smoking, the project was designed to learn more about how smoking cessation aids might help the clinic’s clients.

Staff found that while some women were interested in hearing about the increased risk for stroke or cancer resulting from tobacco use, many were motivated to quit smoking due to a desire to save money or concerns about the physical effects of smoking such as wrinkles and yellow teeth. Staff also had to dispel myths about quitting smoking that many clients had been told. For example, several women reported that their physician had told them not to quit smoking during pregnancy as it would be stressful for the baby. Staff had to respond by providing current information while not discrediting other professionals.

Overall, staff found that there were few absolute rules about what would work best for their clients and that supporting women requiring a tailored case-by-case approach. Many women required support in breaking the “hand-to-mouth” habit; staff made straws, stir sticks, and licorice available for those women who had quit smoking and NRT inhalers for women who were reducing their tobacco use. In groups and individual counseling sessions, women were offered NRT gum as a substitute for leaving the session to go outside for a smoke break. Staff also worked with women to come up with individual solutions. For example, in some cases, pregnant women were initially advised to take the NRT patch off at night. But, for women who were getting up to smoke in the middle of the night, they experimented with leaving it on overnight to see how that affected their overall sleep.

Building confidence and celebrating successes, no matter how small, were important. Many women were fearful that quitting smoking could lead to relapse related to quitting other substances (e.g., marijuana use or crack cocaine use). Staff had open discussions with women about the connections between stress, smoking, and poverty to help women develop awareness of the influences on their smoking and to appreciate their successes.

Clear and ongoing communication between staff members of the multidisciplinary team was also important. Staff worked to develop short and consistent messages about smoking and shared their findings about dosages (e.g., often important to aim higher as smoking tends to be under-reported) and effective strategies (e.g., many women preferred using NRT gum before moving towards the patch as it gave them an ‘instant fix’).

**THE NEXT STEP**

1. In your personal or professional experience, what are the benefits of using smoking cessation drugs and nicotine replacement therapies as part of a quit smoking approach? Have you noticed differences in strategies and successes between men and women?

2. In your community, how available and accessible are smoking cessation drugs and nicotine replacement therapies? What is known about them?
WOMEN-CENTRED TOBACCO REDUCTION AT A COMMUNITY HEALTH CENTRE

This diagram from *Liberation! Helping Women Quit Smoking: A Brief Tobacco Intervention Guide* helps health care providers translate women-centred principles to quitting smoking into practice. Health care providers at the Maxxine Wright Community Health Centre tailored this model to their community and population.

**ENGAGING**

| Build a relationship with her. | Listen to her needs, concerns, and strengths without judging her or assuming her priorities. |
| Develop a collaborative understanding of how smoking is impacting her life. | Is poverty causing her stress, which leads her to smoke, which leads to increased financial stress? How is smoking impacting how she feels about her body? |
| Understand and address her beliefs about smoking. | For example, some women say that their doctors told them not to quit during pregnancy due to stress on the baby; address this myth by providing accurate information. |

**GUIDING**

| Understand her reasons for smoking. Ask how these needs could be met. | Does she smoke to deal with stress? Are there other ways she deals with stress? Does she have other competing priorities for change? Is she afraid she might fail if she quits? |
| Help her find the motivation to reduce or quit. | For example, ask: what would you do with the extra money? |

**PLANNING**

| Assess reduction or cessation strategies that work for her. | Provide her with options for strategies and ask which fit for her. Hand to mouth habits can be hard to break, suggest having carrots or straws available to chew on. |
| Adjust the strategies to work for her. | If women are getting up through the night to smoke, suggest trialing leaving the patch on overnight. Keep the barriers to NRT low; the multi-day inventory may not work for her; if not then find another way to assess smoking. Consider using gum as well as the patch, to get the nicotine levels up before the patch starts to work. |
| Help her prevent relapse | Don’t lower NRT before she is ready. Continue to provide support by asking how her strategies are working for her. |
DISCUSSION GUIDE

- What have you noticed about how tobacco issues, in general, and for women, in particular, are treated within the health and social service system?

- In your personal or professional experience, how does quitting smoking (or other forms of tobacco) differ between men and women? What are some of the issues that may be unique to or more serious for women?

- Overall, interventions to address tobacco use with pregnant women have not been resoundingly successful. How does this fit in with your experience? What are some alternate approaches to addressing tobacco use in the perinatal period that might work in your context?

- How is your program/agency linking with other programs/agencies in a position to support women’s health and reduce harms related to tobacco?

- What can you do in your role to shift perceptions and awareness of issues related to women and tobacco?

- What can be done to support women exposed to secondhand smoke in the workplace, in public transportation, or in the home?

- What opportunities are there for staff education for learning practice skills such as motivational interviewing? How does your work environment support ongoing learning and sustainability?

- When you think about how attitudes and beliefs towards tobacco have changed in your lifetime, what do you think has been effective in contributing to these changes?

Production of this resource was made possible through a financial contribution from Health Canada. The views expressed herein do not necessarily represent those of Health Canada.

Visit [www.expectingtoquit.ca](http://www.expectingtoquit.ca) and [www.coalescing-vc.org](http://www.coalescing-vc.org) for other work on women and tobacco by the British Columbia Centre of Excellence for Women’s Health.